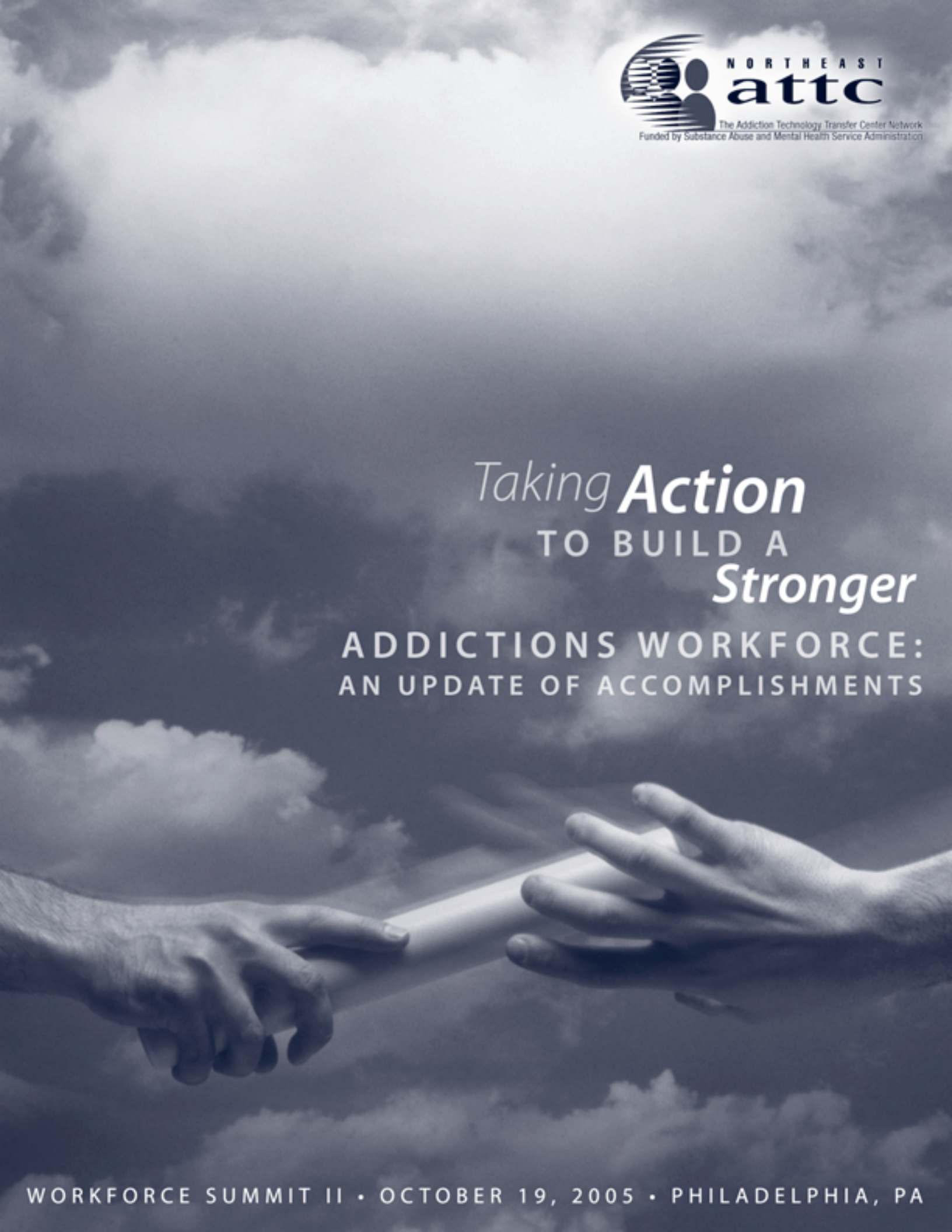
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Funded by Substance Abuse and Mental Health Service Administration
Taking Action
TO BUILD A
Stronger
ADDICTIONS WORKFORCE:
AN UPDATE OF ACCOMPLISHMENTS
WORKFORCE SUMMIT II • OCTOBER 19, 2005 • PHILADELPHIA, PA

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At the time of printing, Charles G. Curie, MA, ACSW, served as the SAMHSA Administrator; H. Westley Clark, MD, JD, MPH, served as the Director of CSAT; and Catherine D. Nugent MS, LGPC served as the CSAT Project Officer.

The opinions expressed herein are the views of the ATTC Network and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA or CSAT. No official endorsement of DHHS, SAMHSA or CSAT for the opinions described in this document is intended or should be inferred.

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"Far and away the best prize that life offers is the chance to work hard at work worth doing."

- Theodore Roosevelt

Special Note:

The SAMHSA-funded Annapolis Coalition on the Behavioral Health Workforce has identified the Northeast Addiction Technology Transfer Center workforce development initiative as an innovative and exceptional practice in substance use disorders education.

Introduction

In 2000, the Center for Substance Abuse Treatment (CSAT) published the National Treatment Plan (NTP) in which they identified workforce development as one of the five major issues that would need to be addressed to improve substance use disorder (SUD)[1] care. At the time of publication, there was a limited amount of data available to assess the extent of the workforce crisis. Since that time, many states have conducted studies (e.g., New Jersey (Pringle and Holland, 2004), Delaware (Knudsen et al., 2005), Kentucky (RMC Research Corporation, 2003), and Florida (Wagner and Tarolla, 2005), etc.) to better understand the current state of and future developmental needs of their SUD treatment workforces.

Overall, the trends in the profession indicate that staff turnover rates are high (Knudsen and Gabriel, 2003; McLellan, Carise, and Kleber, 2003), many agencies are having difficulty recruiting and training a sufficient number of qualified professionals to meet current needs (Northeast Addiction Technology Transfer Center [NeATTC], 2005; Gallon, Gabriel and Knudsen, 2003; Hall and Hall, 2002) and many agencies are understaffed and cannot meet treatment demand (CSAT, 2000; Therapeutic Communities of America, 2005). In addition, salaries are extremely low in comparison to salaries in other healthcare and service fields such as teachers and/or nurses (CSAT, 2000; NeATTC, 2005), the workforce is aging (Harwood, 2002), and provider demographics do not tend to match with the demographics of the individuals they serve (Mulvey et al., 2003).

As a result of new data confirming the current state of the SUD workforce crisis, leaders on the national, state and local levels have applied a multitude of strategies designed to strengthen their respective SUD treatment workforce. In 2001, New York State initiated a program of workforce assessment and development. This effort included the creation of a new Bureau of Workforce Development " … to promote professionalism in the field of addictions; and to implement policies that would counteract the disturbing trend in the declining number of qualified workers in New York State's addictions field" (New York State Office of Alcoholism and Substance Abuse Services [OASAS], 2002, p.1).

To aid the Bureau in evaluating the current state of the SUD treatment workforce, then Commissioner of OASAS, Jean Somers Miller, organized Regional Development Focus Groups throughout the state. OASAS worked with New York State's provider association, the Alcoholism and Substance Abuse Providers of New York State, Inc. (ASAP), and used the focus groups to identify problems with staff recruitment, retention and professional development; determine which recruitment and retention strategies have been successful and which have failed; and solicit recommendations for a statewide Workforce Development Plan for the SUD profession (OASAS, 2002). The eleven focus groups included 125 individuals representing 116 different organizations (OASAS, 2002) who together clarified the crisis state of the SUD treatment workforce in New York:

> Programs are typically understaffed; vacancies are difficult to fill, staff are stressed out, underpaid, and often performing duties for which they have not been adequately trained; staff turnover continues to climb; complying with regulatory staffing mandates is becoming more and more difficult; career advancement opportunities are limited or non-existent; and the work environment is typically unappealing, when compared to other career options. (OASAS, 2002, p.3)

1 Substance use disorder/dependence is then the later and more severe stage of problematic substance use. Substance dependence is further defined as described in the American Psychiatric Association (1994) Diagnostic Criteria from DSM-IV.

No greater challenge exists for the addictions workforce in prevention and treatment today than to sustain and build this workforce.

— Michael Flaherty, PhD
Principle Investigator, NeATTC/Executive Director, IRETA

In June 2002, representatives from ASAP, the Institute for Professional Development in the Addictions (IPDA), the New York State Conference of Local Mental Hygiene Directors (CLMHD) and OASAS formed a task force to address recommendations of the focus groups and initiate a comprehensive SUD workforce development plan for the state. Based on focus group recommendations and assessment of needs, OASAS and the task force began a number of initiatives including reengineering the credentialing process, expanding training opportunities, instituting a day of professional recognition, and many others (OASAS, 2004).

In 2003, New York State brought its growing experience in workforce development to the NeATTC to help the other states in the region, New Jersey and Pennsylvania, begin workforce development programs of their own. The NeATTC has coordinated efforts between the three states including technical assistance to New Jersey and Pennsylvania workforce development task forces by the NeATTC workforce development lead in New York State, two workforce summits, a monograph documenting the discussions and ideas from the first workforce summit on January 27, 2004 (NeATTC, 2004), a newsletter documenting progress on workforce development efforts (NeATTC, 2005), and the New Jersey Workforce Survey which documents the state of the New Jersey SUD treatment workforce between September 2003 and October 2004. The NeATTC continues to facilitate workforce development efforts by providing forums in which leaders from each state gather to discuss ideas, share challenges, and devise solutions.

On October 19, 2005, the NeATTC held its second Workforce Summit where leaders from each state gathered to share updates on their workforce development programs, discuss challenges to implementation, and discuss new directions for workforce development. This monograph is a product of that Summit. Its goal is to serve both as a summary of ideas discussed in the Summit and as a model for other regions and states concerned about the condition of their SUD treatment workforce. It will describe the strategies used by the NeATTC, New York, New Jersey and Pennsylvania, the outcome of those strategies when available, and next steps that the region and its member states are either considering or were suggested by Summit participants as possible options. It is the intention of the NeATTC that the strategies employed both in the NeATTC facilitation process and at the individual state level and described in this report will stand as a model for workforce development programs across the country and provide clear strategies by which other states can begin or continue to build their own SUD treatment workforce.

Structure of the Monograph

This monograph is composed of four sections.

Section I defines the problem with which the SUD treatment profession is dealing. It briefly describes the events and circumstances leading to the national SUD treatment workforce crisis and it highlights the main environmental issues which have led to and perpetuate the crisis. The section closes by describing the current state of the national workforce as depicted by Richard Kopanda, then Deputy Director of CSAT.

Section II outlines the history of the workforce development initiative in the NeATTC region, beginning with the innovative workforce development program in New York. It also describes the current state of a portion of the NeATTC workforce as characterized by data from the 2004 workforce survey conducted in New Jersey (Pringle and Holland, 2004).

Section III describes the national strategies SAMHSA/CSAT and The Annapolis Coalition have used in the past and are currently using to complement state and local workforce development strategies. It also describes the strategies New York, New Jersey and Pennsylvania have used and are currently using to build their SUD workforces. Where available, outcomes are reported for the strategies. Where outcomes are not available, expected benefits of the strategies are reported. The regional and state strategies that have been successful as well as those currently in use are offered here as strategies which any region or state can use to begin or further build their workforce development programs.

Section IV details activities that national agencies and groups are planning to take and recommended actions for the NeATTC and its member states voiced by Summit participants in their break out sessions. The participants' proposed actions are not necessarily the steps which the states will take in the future, but they comprise the ideas frontline workers in the NeATTC formulated for further workforce development based upon past and ongoing initiatives. The proposed regional and state strategies are intended to stand as useful and creative ideas other states and regions can consider using to help build their workforces.

Workforce Summit Speakers:

Joyce Boissell, MBA, Training Officer, NeATTC/IRETA

Gene Boyle, Director, Pennsylvania Bureau of Drug and Alcohol Programs

Michael T. Flaherty, PhD, Principal Investigator, NeATTC/Executive Director, IRETA

Carolann Kane-Cavaiola, MA, Director, New Jersey Department of Human Services, Division of Addiction Services

Richard Kopanda, MA, Deputy Director, CSAT

John A. Morris, MSW, Vice Chair, Annapolis Coalition

Shari Noonan, Acting Commissioner, New York State Office of Alcoholism and Substance Abuse Services

Janice Pringle, PhD, Scientific Director, NeATTC/IRETA

How can we convey the true agony that providers in the SUD field are in without losing the interest of those people who we are asking to make decisions?

— Workforce Summit Participant

Section I: Defining the Problem

The History of the Workforce Crisis

Over the past few decades, the context in which SUD treatment operates has changed dramatically. During the 1970s, the SUD treatment profession experienced explosive growth, fueled largely with training initiatives by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA; White, 1998). This growth was made possible by the expansion of state and federal budgets for SUD prevention and treatment, as well as the fact that SUD treatment became reimbursable through insurance (White, 1998). However, the rapid growth in the profession led to stiff competition among treatment facilities and, eventually, less than ethical conduct (White, 1998). As a result of the problems within the profession, managed care began to take over control of treatment facilities. At the same time, federal drug-control policy re-criminalized SUDs with a focus on law enforcement and a "zero tolerance" policy for drug use (White 1998, p. 283-284).

In the late 1980s and early 1990s, due to the heavy regulation by managed care and the financial limitations such regulation imposed, SUD treatment changed from largely inpatient and residential care to outpatient programs. At the same time, many people became afraid to seek SUD treatment due to the re-criminalization of drug use which increased societal stigma. As a result of the shifts from inpatient to outpatient and illness to criminalization, many SUD treatment programs and facilities were forced to close or consolidate (White, 1998).

Unfortunately, the reduction in programs, and therefore staff ,was more severe than the decline in treatment demand which led to fewer openings in treatment programs. In addition, most of the changes to the organization of service delivery, the workforce, and the provision of services imposed by managed care occurred "without the benefit of clinical or policy research" (Weisner, McCarty and Schmidt, 1999, p. SP57). This lack of empirical support and early-on misleading comparisons between residential and outpatient outcomes, which did not factor in severity of illness, and what amounted to an unregulated or credentialed workforce fueled skepticism about the effectiveness of SUD treatment (Hanson, 1998). All these events combined to create a SUD treatment crisis across the country from which the profession is still struggling to recover.

Barriers to SUD Treatment Workforce Development

While the historical basis of the workforce crisis is clear, there are a number of factors which perpetuate this crisis. In many documents dealing with workforce issues across a number of trades and professional disciplines, the problem is often broken into the following strategic areas:

Identification of and research on specific workforce issues and comprehensive strategic planning to include:

- Recruitment of new professionals (including benefits, salary issues, working conditions, personal satisfaction, challenges, potential impact on society, etc.);
- Pre-service education of new professionals (capacity building and relevance);
- Continuing professional education (knowledge and skill enhancement);
- Staff retention (human resources management);

- Service improvement strategies (process improvement, clinical supervision, adoption of empirically supported practices, use of technology); and
- Service delivery system building (efficacy, cost-benefit, reimbursement rates based on direct and indirect unit costs, etc.).

However, since this monograph reflects discussions from the Summit, the strategic areas presenting the greatest barriers to workforce development used in this publication are the common themes which were identified through examination of Summit proceedings. These strategic areas are financing[2] or lack thereof; stigma experienced by both individuals receiving treatment and providers; system fragmentation in both SUD care provision and financing; and lack of technological capabilities. All of these environmental factors combine to make it extremely difficult to fight the current workforce crisis on any level. Future NeATTC workforce development documents will use the above broader strategic areas and relate them to participant-identified barriers. The NeATTC will also coordinate its work with upcoming SAMHSA/CSAT and Annapolis Coalition guidelines.

Financing

Throughout Workforce Summit II, participants constantly cited finances, i.e., lack of revenue, as the major barrier to reversing existing workforce trends. The current payment structures for chronic illness treatment, like SUD treatment, are based on an acute-care fee-for service model (Wagner et al., 2001). That is, programs and agencies are reimbursed for how much actual SUD treatment time or units they provide for individuals. Unfortunately, there is a limited amount of time that a professional can spend with an individual due to administrative and unfunded collateral responsibilities. In the NeATTC workforce survey in New Jersey, staff spent an average of 37% of their time on administrative tasks, 21% of which was paperwork, and directors spent 76% of their time on administrative tasks, 25% of which was paperwork (Pringle and Holland, 2004).

Other studies have cited comparable rates with directors spending 73% to 87% of their time on administrative duties and staff spending 36% to 42% of their time on administrative duties (Knudsen et al., 2005; RMC Research Corporation, 2003). In addition, a fee-for service structure, unless specifically calculated as such, leaves little or no room for professional development, e.g., training, clinical supervision, mentoring, fellowships, etc., since it would mean less time spent with individuals requiring SUD treatment. In essence, when a professional takes time away from the clinical setting to attend training, there is one less person to provide SUD treatment and, by extension, one less person who is billing for treatment or generating revenue. While SUD professionals recognize the long-term benefits of training, agencies simply cannot afford the immediate costs of training despite the benefits that agencies could eventually derive from long-term professional development. This is also a problem in workforce retention since few professional development opportunities often means few advancement opportunities. In the NeATTC workforce survey, 25% of the staff surveyed cited lack of job growth opportunities as a source of job dissatisfaction (Pringle and Holland, 2004).

Workforce development is ultimately one of the best investments we can make to improve patient care.

— Shari Noonan, Acting Commissioner, New York State Office of Alcoholism and Substance Abuse Services

2 Financing can mean revenue from Medicaid, insurance companies, and managed care or funding from local, state and federal entities.

With limited funds coming into agencies and programs, both from revenue for services as well as funding from government sources, compensation for SUD treatment professionals tends to be low (CSAT, 2000). One of the most important factors limiting salaries is that agencies and state authorities have undervalued clinical services. Agencies often do not have a thorough understanding of their unit costs (factoring in both direct and indirect costs). Necessary administrative costs such as clinical supervision, workforce development, adoption of research-based treatment methods, health and retirement benefits often are not factored into the fees assessed for clinical service. As a result the fees charged by agencies and those established by regulators are artificially low. Such is not the case in other sectors of health care, which have a well established formula for determining costs and fee structures. Any factor which affects salaries leads to problems when trying to recruit and retain qualified personnel, especially for what tend to be high-stress jobs. Numerous surveys indicate that a majority of counselors earn between $15,000 and $34,000 per year (Knudsen and Gabriel, 2003; Pringle and Holland, 2004; RMC, 2003). In the NeATTC workforce survey, 69% of staff and 64% of directors cited lack of interest due to salary as a major difficulty in trying to fill open positions (Pringle and Holland, 2004). Other studies from the Pacific Northwest (Knudsen and Gabriel, 2003), Delaware (Knudsen et al., 2005), Kentucky (RMC Research Corporation, 2003), and Florida (Wagner and Tarolla, 2005), also cited lack of interest due to salaries as a major barrier to recruiting and retaining employees. Limited funds inevitably impact benefits, such as health care and retirement, which can be major incentives for job seekers in lieu of higher salaries. The SUD profession in Pennsylvania also faces significant competition from managed care companies. In fact, many credentialed professionals have left the SUD profession to work in managed care, where they are hired for jobs such as approving service utilization, because they can make more money.

In order to boost revenues, many agencies have moved toward the medical model, i.e., relying more on Medicaid dollars, to bring in money primarily for agency survival and, secondly, for staff retention. However, as agencies move toward that model, Medicaid tends to determine which individuals seeking SUD treatment providers see. Many programs that have adopted this model end up chasing the dollars while programs serving insurance patients and the working poor are barely surviving. This can severely limit SUD treatment access for much of the treatment-seeking population (Alexander, Nahra, Wheeler, 2003). It also builds an indirect but powerful cost shift to public agencies.

Lack of SUD program funding also negatively impacts jobs for people with higher degrees such as social workers, psychologists, nurses, and physicians. There can be great tension within the profession between those who push for greater professionalism through higher degrees and the treatment facilities that cannot afford to pay these newly educated people. For example, in New York State, there are more Credentialed Alcoholism and Substance Abuse Counselors (CASACs) in higher positions, because agencies simply cannot afford social workers. Greater diversity of training and experience that a range of degrees represents would ultimately improve quality of care and help to allay general public skepticism toward the effectiveness of SUD treatment.

Lack of revenue also can lead to a decrease in the length of treatment episodes. Shorter treatment episodes are often the result of limits to individual's insurance benefits (Pourciau, Sanders, Buckel, 1992), restrictions by managed care (Galanter, Keller, Dermatis, Egelko, 2000; Lemak and Alexander, 2001), and lack of adequate local, state, or federal subsidies to provide treatment to meet current and future demand (Amaro, 1999). Studies indicate that the duration of care is closely linked to improved positive treatment outcomes (McCusker, Stoddard, Frost, Zorn, 1996; Moos, 2003; NIDA, 1999). It follows that without the ability to provide SUD treatment for an adequate period of time, professionals will not see positive results of that treatment. In the NeATTC workforce survey, 57% of staff and 65% of directors cited commitment to treatment as a source of job satisfaction (Pringle and Holland, 2004). Without the ability to see positive results of treatment, it is understandable that providers lose their motivation to continue practicing in the profession. Some of this is beyond provider control. Many insurance companies put caps on the number of treatment episodes and the number of visits within each episode (Pourciau et al., 1992). This places providers in frustrating positions where they are unable to provide an adequate amount of care or receive the personal satisfaction associated with adequate lengths of stay[3].

Stigma

The stigma[4] associated with SUDs is another factor contributing to the workforce crisis. While the medical field is increasingly recognizing SUDs as a chronic or reoccurring illness that changes brain structure and function, it is difficult to change the entrenched beliefs of the general public and those who need treatment in relation to SUDs. Persistent stigma can be attributed to the continuing practice of treating SUD as an acute illness (O'Brien and McLellan, 1996; Kaplan, 1997; McLellan et al., 2000; White et al., 2002) which perpetuates the perception that treatment is ineffective, the gap between research and practice as relates to treatment efficacy (Carroll and Rounsaville, 2003) and the widely held belief that substance dependent individuals are of weak moral character and, therefore, undeserving of treatment (Leshner, 1997; White, 1998; Zerger, 2002). All of these ideas and practices have led to the stigmatization not only of individuals receiving treatment for SUDs, but also of professionals who treat addicted individuals or are in some way related to the SUD profession. Many workforce surveys cite stigma as a major barrier to both retaining and recruiting qualified personnel (Knudsen and Gabriel, 2003; Pringle and Holland, 2004; et al.) In addition, persistence of public skepticism of SUD treatment efficacy (Fingarette, 1989; McLellan and Meyers, 2004; Peele, 1989), criminalization of SUDs (Pallone and Hennessy, 2003; White,1998), and limited professional support of SUD as a chronic illness (White, 2005) serve to perpetuate and even increase stigma which makes it difficult to rally public support and advocate for policy change which could contribute to improved recruitment and retention.

3 The adequate length of stay is defined by NIDA (1999: 14), which states, "Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer often are indicated."

4 Webster's Dictionary defines stigma as "Any mark of infamy or disgrace; sign of moral blemish; stain or reproach caused by dishonorable conduct; reproachful characterization" ("Webster's Dictionary," 2006). Leshner (1997) characterizes stigma of individuals with SUDs as the belief that "Drug addicts are weak or bad people, unwilling to lead moral lives and to control their behavior and gratifications."

System Fragmentation

Many of the problems with the provision of SUD care which filter down to affect individual providers reflect problems in the larger healthcare delivery system – unnecessary fragmentation in both care provision and financing of that care (Shi, 2004). Without "systemwide planning, direction, and coordination" there tends to be much "duplication, overlap, inadequacy, inconsistency, and waste, which leads to complexity and inefficiency" (Shi, 2004: 5). In the SUD profession, this fragmentation manifests itself through inefficient communication between stakeholders within and outside the SUD treatment profession which can be characterized by unclear boundaries and responsibilities between various sectors which address SUDs such as general medical practice, education, criminal justice and social welfare (Pincus, 2003). Taking into account the large number of SUD treatment modalities and the plethora of special interest groups, it is imperative that SUD treatment provide coordination and continuity of individual-focused care despite these complexities (Vanderplasschen, De Bourdeaudhuij, Van Oost, 2002). One study conducted by Wells, Lemak and D'Aunno (2005) finds that interorganizational relationships can improve both access to care and quality of treatment. For example, supporters of 12-step programs and supporters of traditional treatment historically, have clashed over which modality works best to bring people suffering from a SUD to recovery. However, leading experts suggest combining efforts would offer an individual the best opportunity for wellness and recovery (White, 2005). In addition, the focus of existing treatment regulators on acute episodes of care without a link to longer-term recovery support services is a set of policies that are not consistent with the existing research and natural history of many SUDs. When frontline workers have more and better resources to help an individual initiate and sustain recovery, individuals in treatment will be more likely to achieve recovery and SUD treatment providers will be more likely to maintain their sense of personal accomplishment, a factor that is tied directly to stress and burnout, two key issues that negatively affect recruitment and retention (Skinner and Roche, 2005).

Technology

In this age of information, the SUD treatment profession lags far behind in technological capabilities. Many treatment facilities, agencies, providers, and others do not have access to technology such as e-mail, internet access, or even voice mail. In addition to communication concerns, many young professionals entering the work world are very technology oriented and will look for jobs with greater technological advantages, such as computerized records, computer-aided decision support systems, and greater access to the medical knowledge base, among others (IOM, 2001). Without these advantages in SUD treatment settings, it is even more difficult to recruit and retain SUD treatment professionals.

The National Workforce

In their National Treatment Plan (NTP), CSAT (2000) highlights the need for more quantitative data in order to understand the current workforce. Although this has changed in the past few years with the publication of many state SUD treatment workforce surveys, many surveys still need to be conducted to fully understand the condition of the SUD treatment workforce in this country. However, the national data we do have helps everyone, from policymakers to practitioners, understand where the national SUD treatment workforce needs to go. Richard Kopanda, Deputy Director of CSAT in 2005, presented specific statistics that describe the composition of the national SUD treatment workforce.

- **The SUD treatment workforce in 1996-1997**
  (Landis et al., 2002; SAMHSA, 2003a)
  - 132,000 full-time staff
  - 45,000 part-time
  - 22,300 contract staff
- **Medical Staff**
  - 17% fulltime staff
  - 31% part-time
  - 47% contract staff
  - Only 63% of degreed staff are full-time (SAMHSA, 2003a).
- **Education Levels**
  - At least 80% have bachelor's degrees (Johnson et al., 2002; Knudsen and Gabriel, 2003; RMC, 2003)
  - There are 53% who have master's degrees (Harwood, 2002)
  - Treatment staff has degrees in many areas, but few have academic courses or degrees specifically related to SUDs (SAMHSA, 2003a).

We need to think outside the box when it comes to compensation issues.

— Richard Kopanda, Deputy Director, Center for Substance Abuse Treatment

- **Accreditation in Education (Taleff, 2003)**
  - There are 442 colleges and universities that offer SUD studies.
  - Most accreditation is at the community college or associate level.
  - No academic accreditation standards exist.
  - Great variation exists in course difficulty, use of evidence-based materials and quality of faculty (Edmundson, 2002).
- **Certification (SAMHSA, 2003a)**
  - From 50-55% of the direct care treatment workforce is certified in some aspect of SUD treatment.
  - Outpatient drug-free agencies have the highest percentage of certified staff.
  - Private facilities have a higher percentage of certified counselors than publicly funded facilities.
  - Private facilities have a lower ratio of certified counselors to individuals receiving treatment than publicly funded facilities.
  - Other professional fields such as primary care physicians (PCPs), psychiatrists, nurses, and others, have very low SUD treatment certification rates (IOM, 1997).
- **Compensation in 2002 (Knudsen and Gabriel, 2003; RMC, 2003)**
  - The average salary was in the low $30,000s.
  - 61% of counselors earned $15,000 - $34,000.
  - 68% of agency directors earned $40,000 - $75,000.
- **Leadership**
  - There is a 53% turnover rate in program managers and directors (per year) (McLellan et al., 2003).
  - Leadership is reaching retirement age.
- **Retention**
  - The staff turnover rate is about 20%, which is double the national average (Knudsen et al., 2003).
  - While 63% of staff has worked in the profession six years or more, 68% have been in their jobs less than five years (Harwood, 2002).

Section II: The NeATTC

The NeATTC Workforce Initiative: New York's Efforts Linking Process with Outcome

During the late 1990s, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) watched the substance use disorder workforce shrink more than 25 percent in less than five years.[5] OASAS considered this decline a workforce "crisis" and feared that if allowed to continue, it would "negatively impact the quality of services provided by the State's alcoholism and substance abuse provider system" (OASAS, 2003, p.1). In response to the crisis, OASAS established the Bureau of Workforce Development in January 2001. The Bureau, in combination with the Alcoholism and Substance Abuse Providers of New York State, Inc. (ASAP) and the Institute for Professional Development in the Addictions (IPDA), proceeded to conduct a comprehensive, three-pronged needs assessment and oversaw development of workforce strategies with focus on barriers in five major categories: compensation, administrative relief, marketing, credentialing/licensure, and organizational culture/best practices. OASAS (2002) published recommendations to address these topical areas in The Addictions Profession: A Workforce in Crisis. Shortly thereafter, OASAS convened a statewide Task Force on Workforce Development to address the nineteen recommendations contained in the Workforce in Crisis report.

The NeATTC took notice of New York's innovations to remedy their workforce issues. They recognized that New Jersey and Pennsylvania, the other states within the region, were also experiencing workforce crises and had the potential to learn from and build on the experiences and successes of New York State's Workforce Initiative. In 2003, the NeATTC began its own workforce development initiative based on statewide focus groups and planning. The NeATTC acted primarily in a facilitative role by learning about early workforce initiatives in New York State and arranging the collaboration and shared learning between the three Single State Authorities (SSAs). Each SSA was responsible for identifying fifteen people in their respective state to serve on workforce development task forces. Over the next year and a half, these state task forces, with NeATTC facilitation, convened meetings where participants discussed workforce development plans and methods for implementation.

On January 27, 2004, the NeATTC gathered a group of stakeholders from New York, New Jersey, and Pennsylvania representing members of provider groups, special population advocacy groups, and certification and credential groups, to name just a few, the three SSAs, national leaders in workforce development research and strategies, and H. Westley Clark, MD, the director of the Center for Substance Abuse Treatment (SAMHSA/CSAT), to address growing workforce concerns in the SUD treatment profession. The summit, "Workforce Development Summit: Taking Action to Build a Stronger Addictions Workforce," brought members of each state together to discuss workforce needs and the challenges and barriers they faced in building an SUD treatment workforce. Presenters offered data to describe the current state of the addictions workforce. States described workforce development programs they were considering and beginning to implement and offered wish lists for workforce needs as they discussed the major issues to overcome. State workgroups focused on creating comprehensive strategic work plans with assigned action steps for the coming year. Attendees and the SSAs left the conference with a sense of collaborative support and a renewed focus on workforce issues.

You must take one step forward every day. It does not matter how little that step is. Do not get lost in the paralysis of analysis.

— Carolann Kane-Cavaiola, Director, New Jersey Department of Human Services, Division of Addiction Services

5 Between early 1997 and mid-2001, there was a decline of 2,300 Credentialed Alcoholism and Substance Abuse Counselors [CASACs] (from 8,500 to 6,200 CASACs) (OASAS, 2003).

You can't make a change unless you can measure it.
— Janice Pringle, PhD, Scientific Director, IRETA/NeATTC

After Workforce Summit I, each state held many task force meetings led by the SSA offices and facilitated by the NeATTC. New York continued to lead the region in workforce development with the Robert Wood Johnson Foundation-funded work of the Institute for Professional Development in the Addictions (IPDA). Through a project entitled, "Practice Relevant Professional Development for the Front Line Addiction Treatment Practitioner," IPDA hosted a series of focus groups and interviews with key stakeholders and organized a stakeholder conference which resulted in two discussion papers about the professional development needs of front-line SUD treatment professionals. In the final phase of the project, IPDA developed a framework that outlines practical approaches to change that can be carried out at an agency level. This framework is designed so that it also can be applied in other allied health professions.

On October 19, 2005, the NeATTC once again gathered a group of stakeholders from New York, New Jersey and Pennsylvania, along with the SSAs and national leaders, to discuss each state's progress in building and strengthening its SUD treatment workforce. Participants in "Workforce Development Summit II: Taking Action to Build a Stronger Addictions Workforce" shared and discussed the successes they experienced and the barriers they came up against while trying to build their workforces in the twenty months between the summits, as well as future directions for further workforce development.

Current State of the NeATTC Workforce

During Workforce Summit II, Dr. Janice Pringle clarified the state of a portion of the NeATTC workforce based on her 2004 workforce survey in New Jersey. These data are essential to understanding the regional workforce so that states can design individualized workforce development plans that will be responsive to specific regional problems and/or gaps in service that may be obscured by more generalized national data.

- **Gender**
  - 64% of directors are female
  - 71% of staff are female
- **Ethnicity**
  - Staff: 57% are white and 32% are African American.
  - Directors: 72% are white and 21% are African American
- **Age of Staff**
  - 35% are age 41 to 50
  - 29% are age 51 to 60
  - 76% are over age 41
- **Education**
  - Staff: 25% have a bachelor's degree and 26% have a master's degree
  - Directors: 25% have a bachelor's degree and 47% have a master's degree

- **Salary**
  - Staff: 47% earn less than $30,000/year and 67% earn less than $35,000/year
  - Directors: 24% earn $40,000/year to $49,999/year and 34% earn $50,000/year to $74,000/year
- **Benefits**
  - Health Insurance: Fully provided for 52% of staff and 54% of directors. It is partially provided for 30% of staff and 32% of directors
  - Retirement Benefits: Not provided at all for 41% of staff and 33% of directors. They are partially provided for 32% of staff and 30% of directors
- **Tasks**
  - Staff spend slightly more than 37% of their time on administrative tasks (21.2% of time is spent on paperwork).
  - Directors spend close to 76% of their time on administrative tasks (25% of time is spent on paperwork).
- **Reasons for Entry into SUD Treatment Profession**
  - Staff: 52% have had previous experience in the profession and 55% had a personal interest
  - Directors: 50% have had previous experience in the profession and 52% had a personal interest
- **Experience**
  - Staff: Have been in the SUD treatment profession for an average of eight years, have been in current position for an average of four years, and have an average of nine years of experience in their roles
  - Directors: Have been in the SUD treatment profession for an average of 14 years, have been in current position for an average of six years, and have an average of 12 years experience in their roles
- **Certification**
  - Staff: 27% are currently certified and 39% have certification pending
  - Directors: 40% are currently certified and 26% have certification pending
- **Methods of Recruitment (Top 3 Responses)**
  - Staff: Newspaper Advertisement (51%), Personal/Informal Contacts (36%), and Agency Human Resources Departments (31%)
  - Directors: Newspaper Advertisement (78%), Personal/Informal Contacts (64%), and Agency Human Resources Departments (42%)
- **Reasons for Difficulty Filling Positions (Top 3 Responses)**
  - Staff: Lack of Interest (Salary) (62%), Insufficient Funding for Open Positions (59%), and Insufficient Number of Applicants Meeting Qualifications (46%)

It is important that states build workforce plans, because the way we view things and the actions we can take at the federal level are very different. We need to work in combination.

— Richard Kopanda, Deputy Director, Center for Substance Abuse Treatment

  - Directors: Insufficient Applicants Meeting Qualifications (71%), Lack of Interest Due to Salary (64%), and Insufficient Funding for Open Positions (59%)

- **Source of Job Satisfaction (Top 3 Responses)**
  - Staff: One-on-one Interaction with Individuals Receiving Treatment (82%), Opportunities for Personal Learning/Growth (61%), and Commitment to Treatment (57%)
  - Directors: Commitment to Treatment (65%), One-on-one Interaction with Individuals Receiving Treatment (64%), and Role as a Change Agent (59%)
- **Sources of Job Dissatisfaction (Top 3 Responses)**
  - Staff: Salary/Benefits (69%), Inability to Influence Agency Decisions (27%), and Lack of Career Growth Opportunities (25%)
  - Directors: Salary/Benefits (48%), Nothing – I am Satisfied (25%), Inability to Influence Agency Decisions (16%), and Lack of Commitment to Treatment (16%)
- **Perceived Status of SUD Treatment Professionals (Top 3 Responses)**
  - Staff: More Often Had a History of Own Substance Misuse (52%), Stigmatized by Association with Substance Abusers (51%), and Less Formal Education or Training (50%)
  - Directors: Stigmatized by Association with Those Who are Addicted (60%), Less Formal Education or Training (59%), and More Often Had a History of Own Substance Misuse (55%)
- **Retention Promoting Activities (Top 3 Responses)**
  - Staff: More Frequent Salary Increases (79%), More Individual Recognition/Appreciation (52%), and Promote Career Growth (42%)
  - Directors: More Frequent Salary Increases (79%), More Individual Recognition/Appreciation (54%), and More/Improved Ongoing Training (49%)
- **Perception of Staff Development Activities (Top 3 Responses)**
  - Staff: Provides In-service Training (71%), Provides Direct Supervision (54%), and Pays Cost of Continuing Education (42%)
  - Directors: Provides In-service Training (83%), Provides Direct Supervision (81%), and Pays Cost of Continuing Education (61%)
  - Staff: Improve Treatment Outcomes (72%), Improve Counselor Performance (69%), and Guide Professional Development (56%)
  - Directors: Improve Counselor Performance (75%), Guide Professional Development (72%), and Improve Treatment Outcomes (68%)

Section III: Workforce Strategies

National Efforts on Workforce Development

Currently, there are major national initiatives in place or being developed by national agencies and groups such as the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) and the Annapolis Coalition on the Behavioral Health Workforce (Annapolis Coalition).

Over the past few years, SAMHSA/CSAT has initiated six workforce development initiatives to create the infrastructure for states to build their workforces.

1. **Environmental Scan.** The Environmental Scan was a direct result of recommendations from the National Treatment Plan (CSAT, 2000). It was completed in 2003 and documented and highlighted demographic and systems conditions. The Scan provided the groundwork for what should come after the Treatment Plan.
2. **Convene Stakeholders.** In 2004, SAMHSA/CSAT convened nine meetings where they gathered approximately 120 people from various disciplines to put together recommendations for the upcoming SAMHSA/CSAT report, Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce. Attendees of the meeting included key stakeholders, professional associates, individuals from colleges and universities, individuals from federal agencies, clinical supervisors, human resource managers, and recovery support personnel. SAMHSA/CSAT also held two regional meetings attended by state directors, providers and the ATTCs. Data from these meetings were shared with participants of Workforce Summit II.
3. **Leadership Institutes.**[6] Between 2003 and 2005, the ATTCs conducted fifteen leadership institutes which have helped to develop and retain a new generation of leaders. SAMHSA itself also has developed a new leadership training program that all senior managers must attend so that the infrastructure will be in place at the highest levels to facilitate change in the SUD treatment workforce.
4. **ATTC Training.** Trainings conducted by the ATTC network are an integral part of the CSAT plan to build a stronger workforce. From leadership development institutes to regional training institutes, the Agency relies on the Network to train the profession on a local level. SAMHSA/CSAT would like to see the ATTC Network develop in the following ways in the future:
    - Collect and analyze data on state, educational institution and other workforce development plans and activities.
    - Serve as the focal point for interactions among SAMHSA/CSAT, national organizations, providers, states, institutions of higher education and other relevant stakeholders in workforce development initiatives.
    - Provide continuing technical assistance on all aspects of workforce development to educational and service institutions.

The Leadership Institute provides SUD treatment professionals with an opportunity to integrate knowledge into daily practice via implementation of a six-month developmental plan that includes continuing education, self-study and a specially designed project.

— Joyce Boissell, MBA, Training Director, IRETA/NeATTC

6 For more information on the Leadership Institutes, see section below entitled, "NeATTC Strategies."

We need to think differently about how we approach workforce issues. The status quo is not enough.

— John Morris, MSW, Vice-Chair, Annapolis Coalition

5. **Strengthening Professional Identity.** The forthcoming CSAT report entitled, Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce, is designed to function as a guide for local and state workforce development efforts. The report encompasses the following six key issue areas: infrastructure development priorities, workforce development priorities (i.e., leadership, supervisory and management issues), recruitment priorities, SUD treatment education and accreditation priorities, retention priorities and workforce related research priorities.

   SAMHSA/CSAT is considering several implementation options for Strengthening Professional Identity. 1) SAMHSA/CSAT could establish an office on workforce development which would serve as a focal point for workforce development within the Agency offices. 2) SAMHSA/CSAT could support development of national core competency standards. 3) SAMHSA/CSAT could partner with institutions of higher education to encourage student interest in the SUD profession and adopt national accreditation standards. 4) SAMHSA/CSAT could facilitate National Health Service Core concept development. 5) SAMHSA/CSAT could strengthen the ATTCs to help achieve specific workforce goals.

6. **Annapolis Coalition on the Behavioral Health Workforce.** Within SAMHSA/CSAT, an agency with many responsibilities and priorities within the behavioral health field, the sole focus of SAMHSA's Annapolis Coalition is workforce development and the development of a national strategic plan for workforce development. The Annapolis Coalition was initially formed by the American College of Mental Health Administration and the Academic Behavioral Health Consortium, both of whom recognized a need within the behavioral health field to promote major reforms in training (Annapolis Coalition on the Behavioral Health Workforce, 2005). In 2005, the Annapolis Coalition was incorporated as a non-profit managed by a Board of Directors and guided by a National Steering Committee of experts in the field. "The mission of the Annapolis Coalition on the Behavioral Health Workforce is to build a national consensus on the nature of the workforce crisis and to promote improvements in the quality and relevance of education and training by identifying and implementing change strategies" (Annapolis Coalition, 2005).

   The diverse group of national leaders that comprise the Annapolis Coalition is currently working on a National Strategic Plan for behavioral health workforce development. The Plan is sponsored by all three centers within SAMHSA (CSAT, CSAP, and the Center for Mental Health Services) and the office of the administrator. However, the goal is a national plan built on broad consensus. It encompasses workforce issues within the context of both prevention and treatment for SUD, mental illness, and co-occurring disorders. The Plan focuses on common issues while respecting the unique needs of specialty areas. A number of themes have emerged in the process of developing the plan:

- The transformative power of strategies focused on primary consumers and families
- The critical importance of explicit management and leadership development (McLellan et al., 2003)
- The need to focus on practical barriers such as financing incentives and disincentives, licensure issues, and others
- The need for systematic recruitment and retention strategies to be linked to explicit career ladders
- Recognition of the paradigm shift which has transformed training to be competency-based, problem-based, built on the concept of life-long learning, utilizing evidence-based teaching and recognizing and employing interprofessional training
- The critical role of oversight organizations in driving (or impeding) change
- The utility of data-driven tracking and continuous quality improvement applied to workforce issues
- The need for national consensus on workforce development and on interdisciplinary infrastructure capable of meeting workforce development needs and sustaining strategies for change

While the Annapolis Coalition as a whole is creating a national plan, each workgroup within the coalition, one of which is the Substance Use Disorder Expert Panel, co-chaired by Michael Flaherty, PhD (IRETA/NeATTC) and Steve Gallon, PhD (Oregon Health and Science University/Northwest Frontier ATTC), has created a sector-specific comprehensive plan. In the case of the SUD Expert Panel, the plan represents a consensus from many perspectives within the SUD profession clearly outlining the changes needed to improve workforce development. It could serve not only as a strategic plan for the profession but also as a unifying point around which professionals can gather to help sustain the SUD treatment workforce. For example, in the fall of 2005 the SUD expert panel was expanded to include more leadership and input from those in recovery.

Although the Annapolis Coalition is focused on national perspectives and policies to transform the behavioral health workforce, the group also recognizes the value of state and local collaborations and initiatives. In an attempt to widely disseminate some best practices for workforce development, Michael Hoge, PhD, and John Morris, MSW, chair and vice-chair of the Annapolis Coalition, respectively, served as guest editors for an issue of the journal Administration and Policy in Mental Health. This issue highlighted articles on implementing best practices in behavioral health workforce education. One of the articles written by Hoge and colleagues outlined "16 recommended 'best practices' that should guarantee efforts to improve workforce education and training in the field of behavioral health" (Hoge et al., 2004, p. 91).

We cannot deliver competent care without a competent workforce.
— Michael Flaherty, PhD, Principle Investigator, NeATTC/Executive Director, IRETA

Strategies

The NeATTC has been taking and will continue to take a facilitation role in workforce development within its region. The Center's main function is to bring individuals from the three states together to learn from and build upon one another's experiences. Although the initiative is based on the significant success achieved in New York State, the NeATTC does not advocate a cookie-cutter approach to workforce development. Each state has different workforce needs, different budgetary constraints, and different political systems to navigate. In addition to facilitating meetings among the states where individuals could create strategic plans and specific action steps to address state workforce issues, the NeATTC and its member states have taken the following recent steps to ensure that workforce development within the region continues and efforts grow stronger. Not all of the strategies noted here are quantifiable since they are either still in the beginning stages of full implementation or have not been fully implemented for a long enough period of time to measure their impact. Where outcomes are available, they are noted with the corresponding strategies. Where they are not available, the expected qualitative value of the strategies is noted.

NeATTC Facilitation Strategies

- **Conduct State Surveys**. While data alone are not a remedy for current workforce issues, they can help to define the problem, thus creating the factual basis for an action plan (Strong, Del Grosso, Burwick, Jethwani, Ponza, 2005; Waters, 2004). In 2004, the NeATTC conducted a comprehensive workforce survey in New Jersey. This information will enable active participants in the process to understand and hopefully change workforce trends that can function to improve treatment outcomes, stem the tide of workforce turnover, and increase the success rate of recruitment efforts, to list just a few of the possible benefits.

- **Conduct a Leadership Institute.** The Leadership Institute is an innovative leadership development program created by the Southern Coast ATTC in collaboration with the Graduate School of the United States Department of Agriculture, and SAMHSA/CSAT Partners for Recovery. The National ATTC office coordinates the program's implementation, and the Institute is offered in all ATTC regions. It is a six-month leadership preparation program which provides a combination of in-depth assessment, traditional training seminars, distance education, and field experience in conjunction with guidance from a specially selected mentor. Participants are chosen from nominations by agency directors and supervisors and are recognized as individuals who have the realistic potential to become leaders, demonstrate a commitment to their agencies, and demonstrate a career commitment to the SUD treatment profession, in general. Overall, the program is designed to retain qualified individuals in the SUD treatment profession by providing opportunities for advancement.

  The Institute utilizes a four-phase design of assessment, training experiences, experiential learning, and recognition which lay a foundation to develop leadership, management, communication, and other key skills. During the course participants – with guidance from their mentors — develop unique projects that contribute to their agency and career development. There is a booster training for all participants approximately half way through the program. Nationally, approximately 180 protégés have completed the program.

The NeATTC conducted its first Leadership Training Institute beginning in September 2004 with graduation in May 2005. Thirteen protégés and twelve mentors participated in the program. The protégés covered a range of SUD treatment responsibilities including, but not limited to, entry level supervisors, administrative personnel and financial personnel. The second NeATTC Leadership Institute began in March 2006 with 20 protégés.

This program has filled and will continue to fill a leadership development void within the SUD treatment profession. By training up-and-coming leaders, the profession will strengthen retention through provision of professional development and advancement opportunities to practitioners (OASAS, 2002; Pringle and Holland, 2004).

- **Convene Region-Wide Workforce Summits and Disseminate Workforce Information.** Through two workforce summits, the NeATTC has created a setting in which states learn from the barriers each faces and the successes they have achieved. More than that, the summits allow individuals from each state to share specific steps taken to achieve change. The summits also serve as checkpoints for each state in which the SSAs must report state progress to the rest of the region. Then members of the region can give feedback on how each state might improve its workforce initiative. The monographs, based on the summits, provide another forum by which the NeATTC can disseminate information to a wider audience about progress on workforce development initiatives within the region, both galvanizing those within the NeATTC to further action and providing examples to which other states or regions can look.

- **Push for Integration of Clinical Supervision into all Aspects of SUD Services.** Clinical supervision is widely recognized as an evidence-based practice which offers effective training and skill development (Dixon, n.d.a). The NeATTC views clinical supervision as both a workforce priority and an ethical concern. As a result, the NeATTC is beginning participation in a series of conferences at the State University of New York at Buffalo that are designed to address many aspects of clinical supervision.[7]

  > The conference provides an opportunity for psychologists (school, counseling, clinical), social workers, nurses, marriage and family therapists, psychiatrists, substance abuse counselors, speech therapists and other mental health professionals to meet and to learn from each other about current issues, practice and research findings related to clinical supervision of students and practitioners. (University at Buffalo, State University of New York, School of Social Work, 2005)

While the conference addresses clinical supervision in a cross-disciplinary context, members of the NeATTC are on the planning committee to insure that clinical supervision within SUD treatment will be represented at the upcoming conferences. Participation in these forums will allow the NeATTC to take an active role in promoting clinical supervision, which, as training, can be a significant factor in staff retention (Dixon, n.d.a).

We all have hope that we can fix the problems, but these problems cannot be solved by one state alone. All of us must bring information to the table so other participants can learn from and take that information back to their own states. — *Gene Boyle, Director, Bureau of Drug and Alcohol Programs, Pennsylvania Department of Health*

7 "Supervision is an intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients she, he, or they see(s), and serving as a gatekeeper of those who are to enter the particular profession." (Bernard and Goodyear, 1998).

- **Work with the Annapolis Coalition.** The Annapolis Coalition works "to build a national consensus on the nature of the workforce crisis and to promote improvements in the quality and relevance of education and training by identifying and implementing change strategies" on a national level (Annapolis Coalition, 2005). Michael Flaherty, PhD, principle investigator for the NeATTC, currently serves as the co-chair on the substance use disorder treatment expert panel and will continue to bring the innovative thinking of the Annapolis Coalition to bear on the current initiative, insuring that the NeATTC and its member states are knowledgeable about a range of workforce development options.

- **Continue the Awareness and Recruitment Campaign.** In concert with NAADAC, the Association for Addiction Professionals, the Central East ATTC and the National Office of the ATTC, the NeATTC is spearheading a campaign designed to make the general public aware of careers in the SUD profession while focusing recruitment on young professionals. The secondary goal of the campaign is to encourage a diverse interest in the SUD profession. One major aspect of the campaign is a recruitment video which targets younger professionals for entry into the SUD treatment profession. When completed, this video will be viewable on the NAADAC and National ATTC websites, and the NeATTC is considering creating a public service announcement from the video. The campaign will also involve posters for schools, billboards for the public, and brochures which can be used by any career counselor and will include information describing SUDs, the benefits of a career as an SUD treatment professional, places SUD treatment professionals can work, information SUD treatment professionals know and what they do, which accredited universities offer majors in a behavioral science field, salary ranges, and many other useful facts. All of the elements of the campaign are expected to boost recruitment.

- **Offer Interdisciplinary Training.** Interdisciplinary training is especially important in light of the fact that patients with SUDs are found in "the practices of almost all physicians" (O'Brien and McLellan, 1997, p. 1840) and brief interventions by physicians can significantly reduce substance use (Fleming et al., 2002). However, 94% of primary care physicians and 40% of pediatricians fail to diagnose a substance use disorder properly (National Center on Addiction and Substance Abuse at Columbia, 2000). In response to this lack of SUD knowledge by other health care professionals and depending on the specific course, the NeATTC offers training in a variety of disciplines so that individuals such as counselors, social workers, psychologists and teachers can receive continuing education credits for credentialing. This allows these professionals to fulfill their continuing education credit requirements while receiving training related to SUD treatment. A better understanding of SUDs and the benefits of treatment will only increase the support SUD treatment providers receive from other disciplines, reducing stigma and creating a more satisfying work environment.

State Strategies and Resulting Accomplishments

- **Create a Comprehensive Plan.** At the outset of their workforce development efforts, each state established a steering committee to create a comprehensive plan for workforce development composed of five workgroups encompassing the areas of compensation, marketing, administrative relief, credentialing and licensure, and organizational culture/best practices – the subjects deemed to be the key areas to tackle. These plans contained actionable steps to achieve the states' specific workforce development goals. New York's comprehensive plan is updated every two years so that it will remain responsive to workforce needs. The comprehensive plans serve each state as a road map to their workforce development program. The following are recommended areas on which states and regions should focus when developing comprehensive plans:
  - Recruit new professionals from social service education programs and discipline-specific programs like social work, rehabilitation counseling, nursing, nurse practitioners, psychology, counseling and human services programs.
  - Establish standards and accreditation opportunities for pre-service SUD studies/SUD counseling training programs, including standards and guidelines for supervised field learning experiences.
  - Offer faculty development programs in a variety of disciplines to prepare and update new and existing faculty respectively.
  - Develop strategies to retain existing staff, including using human resource management concepts, providing enhanced clinical supervision, and basing fees and contracts on actual unit of service costs that incorporate necessary indirect, supervisory and program development expenses.
  - Promote the adoption of continuing education standards and programs that assure knowledge and skill development and increased utilization of empirically supported prevention and treatment strategies.
- **Concentrate State and Federal Advocacy Efforts.** In anticipation of the 2005 fiscal year, IPDA and ASAP made advocating for more money their single most important political issue. They focused all advocacy efforts on one issue instead of presenting a laundry list of items to the State Legislature. They provided the governor's office and OASAS with hard data which included documenting actual cost increases for agencies and pass-throughs for staff with a focus on rising health care costs instead of salary needs. Their efforts succeeded largely because all relevant agencies worked together to make this happen. As a result, New York received an additional $8.5 million in the Governor's budget for investment in the residential treatment system. Most importantly, the money was not a one-time award but rather has been added to the base budget for the future.

"I've always believed that success is dependent on effort. The collective effort demonstrated in Pennsylvania, New Jersey and New York has already produced promising results and bodes well for achieving our respective workforce goals in the future."
– Neil Grogin, Associate Commissioner, Management Resources and Quality Assurance, New York State Office of Alcoholism and Substance Abuse Services

- **Increase Visibility of and Access to Certification Programs.** New York has worked to increase the access to and visibility of Credentialed Alcoholism and Substance Abuse Counselor (CASAC) educational certificate programs by partnering with academic institutions to offer these programs. New York is also partnering with Hostos Community College in piloting a bilingual CASAC certificate program. Both of these initiatives are expected to stimulate recruitment by increasing access to state-approved certificate programs and ensuring there is a pool of well-trained, culturally diverse professionals. In addition, OASAS implemented a CASAC Trainee designation in 2001, designed as an initial step in the process to becoming a full-fledged CASAC. In four years, nearly 4,300 CASAC Trainee certificates have been issued, and there are currently approximately 2,800 CASAC Trainees statewide. In four years, 1,400 CASAC Trainees have completed the credentialing process and become full-fledged CASACs.

- **Retain Professionals Through Credentialing Program.** New York has removed some of the barriers to retaining seasoned credentialed professionals and recertifying lapsed-credential professionals by instituting a new policy for late renewals. Credentials will be conditionally renewed pursuant to a waiver request of the applicable regulatory provisions until OASAS can work to change the regulations. The conditional renewal will be valid for up to 180 days subject to satisfying evaluation of competency and ethical conduct, continuing professional education, and fee requirements. This will help the state retain some of its most qualified professionals and possibly affect over 4,000 individuals.

- **Recognize Hard-Working Professionals.** Recognition in general, but especially recognition associated with financial reward, is often identified as an effective retention incentive (Hornblow, 2002). New York understands the role professional recognition plays in both marketing the profession to potential new providers as well as boosting morale for current SUD professionals. In support of the state's addictions professionals, ASAP, a provider organization, hosts an annual Addictions Professionals Day. In 2005, OASAS participated in the 3rd annual recognition day by offering financial rewards to outstanding professionals. Each CASAC and Credentialed Prevention Specialist (CPS) or Credentialed Prevention Professional (CPP) of the year will have the $150 biennial renewal fee waived for the lifetime of their credentials. In addition, the CASAC Trainee of the year will have all exam fees required to complete the credentialing process waived.

- **Reduce Paperwork.** As noted in Section I of this report, both staff and directors spend a significant portion of their time on administrative tasks, especially paperwork. As a response to this problem, New York State explored the potential use of a unified client progress reporting system, which is a single form that chemical dependence providers can use to report on an individual's progress to multiple referral agencies such as parole, probation, child protective services, drug court, and many others. This reporting system is expected to significantly reduce paperwork, allowing professionals to spend more time providing services to individuals, a factor which is cited as a source of job satisfaction (Pringle and Holland, 2004) and will aid in retention.

  Pennsylvania has also made great strides in reducing overall administrative burden, especially paperwork. In the new five year contract with Single County Authorities (SCAs), the Bureau of Drug and Alcohol Programs (BDAP) has removed many prescriptive requirements, giving SCAs more local decision-making flexibility and effectively streamlining the administrative process.

- **Improve Organizational Culture and Best Practices.** In 2005, New York finalized a list of 10 principles and practices that will assist agencies in developing a strategic and integrated approach that involves every major aspect of an organization in creating an atmosphere of excellence. Improving the work environment is expected to greatly aid retention efforts for otherwise stressful jobs.
- **Conduct the Residential College.** The Residential College program of New Jersey "is a two-week residential program, whose purpose is to immerse counselors into the SUD treatment professional community through hands-on experience with lead trainers" (Addiction Treatment Providers of New Jersey, 2006). The program is geared toward people who need a final push to finish their Certified Alcohol and Drug Counselor (CADC) certification. Through 2005, fifty-seven people have completed the residential college program. Helping professionals complete their CADC degree is expected to increase the number of qualified professionals in the state.
- **Stand Up for Appropriate Salaries.** Each time the New Jersey Department of Human Services, Division of Addiction Services, rewrites contracts, they ask providers to write in a salary range distinct for certified and licensed alcohol and drug counselors. With agencies providing concrete salary ranges, professionals will feel they have room to grow salary-wise and there will not be a need to leave their agency to make more money, thus promising to reduce staff turnover.
- **Include Recovery Mentors.** In 2005, New Jersey introduced a certificate for recovery mentors so that the profession can draw in new people and retain individuals who are in recovery. This certification is not designed to lead to other certifications and emphasizes the importance of all stages of care and the need for mentors through these stages. Recovery mentors are expected to enhance traditional treatment and guide individuals into long-term recovery. The state expects this will improve long-term treatment outcomes, thus reducing stigma of SUDs and the misperception that treatment does not work which can ultimately serve to improve recruitment.

  Pennsylvania is also working to include individuals in recovery in the SUD treatment profession. The state is developing partnerships with recovery organizations in order to identify methods to effectively engage volunteer and paid recovery community individuals. This collaboration is expected to bring more SUD service providers into the profession.

- **Connect People and Jobs.** In 2005, New Jersey compiled a resource book for college and university field instructors designed to assist students in easily finding a field placement which works best for both the student and field instructor. The book includes 48 agencies that accept field placements, describes what type of supervision the agencies provide, identifies where the agencies are located, and specifies the degree required for the position, if any. This resource will make it easier for qualified job seekers and employers in the SUD treatment profession to connect.

We need indepth training and we need to develop a group of colleagues who can speak to each other.

— Carolann Kane-Cavaiola, Director, New Jersey Department of Human Services, Division of Addiction Services

There is a role for everyone in responding to this national crisis, much as is the case in responding to a natural disaster.

— John Morris, MSW, Vice-Chair, Annapolis Coalition

- **Market the SUD Treatment Profession**. In order to positively increase SUD treatment job visibility, New Jersey Associated Treatment Providers (ATP) hired a professional to develop state goals for marketing and public relations. The strategies to achieve goals include marketing outreach to college fairs and dissemination of a comprehensive brochure which answers many questions for those interested in pursuing a career in the profession. Specialized help in marketing and public relations is expected to increase the visibility of jobs in the SUD profession, help reduce the stigma of such jobs, and increase recruitment of young people.

- **Provide Scholarships.** In order to enable professionals to attain certification and attend trainings New Jersey provides scholarships for professionals. Since the first workforce summit, the state has provided 90 scholarships to help professionals achieve certification as chemical dependency associates.[8] The state also provided at least 1,000 scholarships for continuing coursework for certified alcohol and drug counselors. Experience with these programs suggests that financial compensation to agencies and programs make training possible for many professionals (National Education Association, 2003), thus improving treatment services, job satisfaction, and, ultimately, recruitment and retention.

- **Offer Creative Training Opportunities.** In New Jersey, all Department of Human Services employees have the opportunity to take basic classes related to SUD treatment to put towards a Chemical Dependency Associate Certification (CDA). These classes are part of the 270 hours required to be a Certified Alcohol and Drug Counselor (CADC). This is a unique program in that it offers all levels of staff associated with human services the opportunity to learn about SUDs and SUD treatment. New Jersey also offers an innovative training program, New Jersey Access Initiative (NJAI), in which mentors are trained to help those recovering from opioid dependence transition into the community. This program provides the average person with basic training related to SUD treatment and entices him or her into the profession through a part-time mentor position. Though different, both of these programs offer creative training opportunities to help introduce more people to the SUD treatment profession. In addition, these programs help human service workers better understand addiction so they may earlier identify and refer individuals with substance use disorders to treatment or other necessary services. Pennsylvania also uses creative training opportunities to draw new recruits into the field. Currently, non-degreed individuals may enter the field as counselor's assistants which affords them the opportunity to receive hands-on training while working on their degree.

- **Use Knowledge Learned from Completed and In-Process Strategies to Develop New Strategies.** Both successful and less than successful workforce development strategies have been useful in assessing what is most effective to address the workforce challenges in a specific state. Constant adjustment and monitoring of strategies is imperative to ensure states remain responsive to SUD treatment profession needs and address those needs using the most efficient, effective and cost-effective methods. Feedback from individuals and states has helped to modify the Leadership Institute, strategies for recruitment, and methods for recruiting individuals in recovery, to name a few.

8 A chemical dependency associate is a marker to indicate that a professional is approximately one-third of the way to CADC certification.

Section IV: Next Steps

During the course of the Workforce Development Summit II, members of the break-out groups identified directions for the NeATTC and their states to build upon past regional and state work as well as to capitalize on national steps that SAMHSA/CSAT and the Annapolis Coalition are currently undertaking.

Next Steps on the National Level

Both SAMHSA/CSAT and the Annapolis Coalition have clear directions for future workforce development efforts. SAMHSA/CSAT most immediately plans to complete the internal review of *Strengthening Professional Identity: Challenges of the Addiction Workforce*, go through the final content clearance process and roll out the report. The agency would like the report to serve as a catalyst for addressing the needs of addiction professionals as well as a guide for developing workforce strategies. SAMHSA/CSAT also intends to develop a National Strategic Plan for Workforce Development. It will be built on previous workforce initiatives and seek broad input from the profession to identify a core set of strategic directions, specific and achievable goals, and a set of high priority action items for addressing workforce needs. One of the main ways SAMHSA/CSAT will bring the National Plan together is through continued support of the Annapolis Coalition.

As a leading advocate for workforce development reform, the Annapolis Coalition will present its Strategic Plan to SAMHSA/CSAT and recommend the following practical action steps for agencies and providers to improve the current state of the workforce:

- Agencies and providers need to evaluate current training expenditures and stop investing in training programs that do not work.
- Agencies and providers need to analyze rate structures to see if clinical supervision and evidence-based training can be rolled into allowable costs.
- Agencies and providers should advocate for competency-based models for assessing staff.
- Agencies, providers and students need to express their dissatisfaction with education providers if the educational system is going to change.

Next Steps on the Regional Level

One of the specific questions moderators asked their break-out groups was what action the NeATTC could take to support state-specific workforce development initiatives. The following recommendations in no way constitute a complete list of next steps for the NeATTC or even next steps the NeATTC is considering taking. It is simply a compilation of suggestions from members of the break-out groups, a wish list, so to speak, as to what they believe the NeATTC could do to build the regional workforce. In addition, the strategies suggested here are intended to specifically address how the NeATTC can assist its member states in combating the barriers outlined in Section I of this monograph. These strategies also stand as suggestions for other regions in a position to help member states build their workforces. While the strategies that follow here are offered to address the environmental barriers to SUD treatment workforce development, the goal of all of these strategies is to either improve treatment or demonstrate treatment effectiveness which will ultimately address all of the barriers. For example, if, as in the first strategy listed below, states can divert money from small, inefficient agencies to larger, more efficient ones, it will allow these larger agencies to increase salaries which will improve retention. This, in turn, will improve continuity within the agency, eliminate the high costs to train new staff (Hoge, 2002), and improve client retention due to continuity of the client/provider relationship (Gustafson, 1991) thus improving outcomes for individuals in SUD treatment who will benefit from longer treatment periods (NIDA, 1999).

Strategies to Address Financial Issues:

- **Encourage Providers to Utilize Economies of Scale.** Currently, there are a number of small treatment organizations, those who have two or three staff who have had no capacity increases for the past ten years, which operate their programs at extraordinarily high costs in relation to the services they offer. The NeATTC can help lower overall treatment costs by encouraging small providers to consider merging or consolidating with larger treatment programs to better utilize limited resources.
- **Explore Alternative Sources for Health Care Benefits.** Benefits, specifically health care, or lack thereof, are often an issue for front line workers in the profession (Knudsen et al., 2005; Pringle and Holland, 2004; RMC Research Corporation, 2003; Wagner and Tarolla, 2005). Unfortunately, employers often cite reimbursement rates as a barrier to attaining the financial margins required to offer such "perks" as health care benefits (CSAT, 2000). Participants in this summit would like to see the NeATTC explore alternative sources for health care benefits such as the possibility of joining the state plan (for non-profits) or banding together as providers to purchase group health care benefits. The NeATTC could conduct a survey of the current provider offered health insurance plans and strategies for containing costs which would form a basis for a plan to band together.

- **Reach Out to Elected Officials.** Many elected officials are receptive to the needs of the SUD profession. Providing such individuals with the information to advocate on behalf of the profession and generate support for state programs could have a significant impact on the ability of professionals in the field to retain, recruit and train staff. One participant suggested the NeATTC conduct commissioner trainings to provide them with information regarding what SUD treatment means to other agencies and how SUDs drive other problems within their agency portfolios. The NeATTC could also offer testimony to support these facts at appropriations hearings and help orient the commissioner's as to major barriers and issues within the SUD treatment profession.

Strategies to Address Stigma:

- **Conduct a Major Public Relations Campaign.** The aim of a major public relations campaign would be to reduce stigma surrounding SUD treatment and the profession, since this is believed to be a major barrier to recruitment. Part of the strategy could include identifying and targeting receptive people to build a stronger base of public support for SUD prevention, intervention, treatment, and recovery. One suggested direction for the campaign is to concentrate on the amount of money the SUD treatment profession saves other systems when people receive proper SUD treatment. For example, "It costs approximately $3,600 per month to leave a drug abuser untreated in the community, and incarceration costs approximately $3,300 per month. In contrast, methadone maintenance therapy costs about $290 per month" (National Institute on Drug Abuse, 2005).
- **Conduct a Major Educational Campaign.** While the above strategy is designed to sell the benefits of SUD treatment, and, by extension, the benefits of choosing employment in the SUD treatment profession, an educational campaign would serve to educate the general public about the chronic nature of SUDs, how substance dependence changes brain functioning, and the effectiveness of treatment for SUDs. If the profession can demystify the nature of SUDs while offering a viable management tool for the illness, the public will be more supportive of SUD treatment in political and other forums.

Strategies to Address System Fragmentation:

- **Help Craft a Common Vision and Universal Language for Marketing and Recruitment.** A common vision and universal language will help unify the marketing vision thus ensuring that both the public and potential new professionals receive a clear message concerning the effectiveness, benefits and cost-benefits treatment provides. Collaborative efforts to craft the vision and language also will help ensure that states do not duplicate efforts. In addition, the NeATTC could develop generalized marketing tools to be tailored to specific state needs.

- **Act as a Conduit for States to Share Resources, Ideas and Newsletters.** The knowledge base in the health care and SUD treatment professions is growing at an astronomical rate (IOM, 2001). One person or organization cannot possibly process and disseminate all relevant information. Therefore, with a central body such as the NeATTC working to funnel efforts, member states could expend less energy on duplicative efforts and more on focused action. The NeATTC could coordinate efforts by holding meetings throughout the year where participants from each state share ideas for workforce development, help develop new initiatives, and discuss what has worked, not worked and why. This forum would encourage a more open and active dialogue from members of each state while widening the resource base available to them. Once a more unified voice of providers, agencies and others is established, the NeATTC also could help establish relationships to politically influential people who are receptive to needs of the SUD field.
- **Create an Informational Campaign for Other Health Care Professions.** Much of the literature shows that a majority of individuals who need SUD treatment are seen by many other health care professionals before they access an SUD-specific treatment professional, if they access specialized practitioners at all (McLellan and Meyers, 2004). However, general health care practitioners rarely form formal collaborations with SUD treatment professionals. A regional entity could help to broker such collaborations between professions by educating general health care practitioners about the benefits working with SUD treatment professionals will allow them to offer individuals in their care.

Strategies to Address Technological Barriers:

- **Help Local Programs Access Physical Technology Resources.** Since resources used to update or acquire technologies such as computers means less money for actual treatment, agencies need to look for technological resources from other sources. Regional bodies like the NeATTC could create lists of state-specific locations which offer computers at low or no cost, such as universities. The NeATTC also could gather information on resources to assist agencies in installing and using such technology. This information could include non-profit technological consulting companies that offer their services at greatly reduced rates to other non-profits, individuals who would be willing to help non-profits or other programs that provide technical assistance to non-profits.
- **Offer Information to States in Many Formats.** Without the most up-to-date technology, agencies in many states cannot access resources such as electronic newsletters. Regional ATTCs could invest in an automated fax system where they can easily fax newsletters containing important training or resource information to agencies in their member states.

Next Steps on the State Level

While the comprehensive plans for each state lay out a general map for the direction of workforce development, SSAs and participants in the break-out groups for Workforce Summit II offered many specific suggestions their states could take to strengthen their workforce efforts. The NeATTC intends these strategies to be examples of next steps any state can use to build its workforce once the infrastructure for workforce development is in place. Not all steps will be appropriate for all states as each initiative needs to be responsive to specific needs within the state. Similar to the regional level, the ultimate goal of all strategies which develop the workforce is to improve SUD treatment which can help reduce stigma, contribute to a case for more

funding and better reimbursements, and improve communication with practitioners outside the profession who can help to support and advocate for SUD treatment. The first two strategies offered below are not specific to one of the barriers listed in Section I of this monograph. The first strategy is a necessary first step for any state which would like to assess the extent of its workforce needs in order to build a strategic plan which can begin to address the problems. The second strategy is crucial to improving service to individuals in treatment and offering them better opportunities for recovery and wellness which is in line with the ultimate goal of the entire profession.

- **Assess Workforce Needs.** The most important action for any state to take before beginning to plan a workforce development program is to assess the current state of the workforce. These data will form the basis of any development program and provide a baseline from which the state can measure its progress. The best way a state can assess its workforce is through a comprehensive survey, such as the New Jersey Workforce Survey completed by the NeATTC (Pringle and Holland, 2004). Once initial assessment is completed, states should institute some method, whether a data collection system or another workforce survey, to track their progress. The subsequent data should be used to make adjustments in existing workforce development programs.

- **Institute Process Improvement Systems to Improve Care for Individuals in Treatment.** While current service practices may often be a barrier to treatment access and retention, there is no single area of SUD treatment that is so readily changeable. Process improvement systems should be specific to agency or program needs. When implemented, these systems have resulted in dramatic improvements in agencies over an 18-month period. As a staff retention measure, it is profound how staff are dedicated to and appreciative of this relatively simple technology. It can also serve as a key vehicle for securing more funds by documenting effectiveness. For example, this often includes double-digit percentage improvements in wait-time, admissions and continuation rates in treatment (NIATx case studies: Axis 1 of Barnwell, South Carolina, 2004; Brandywine Counseling, 2004; St. Christopher's Inn, 2004; et al.).

Strategies to Address Financial Issues:

- **Use Efficacy of Treatment Information to Make a Case for Enhanced Funding and Better Reimbursement.** Treatment providers need to more effectively demonstrate the efficacy of treatment if they hope to expand and diversify their funding base. This case needs to be made powerfully and should utilize data that graphically demonstrate the cost-benefits of providing specialized care for SUDs. The state of Washington has been very successful in using data to secure additional state funds for addiction treatment. In 2005, the legislature approved an unsolicited $32 million increase for treatment services because the SSA made the case for state savings by funding treatment instead of incarceration, treating people in emergency rooms, and investigating child abuse/neglect cases (Washington State Department of Social and Health Services, 2005). States can also advocate for independently practicing clinical drug and alcohol counselors to receive proper reimbursement from managed care. This will create more incentives for direct care providers to stay in the profession.

- **Advocate for Cost of Living Increases.** As outlined in Section I of this monograph, financial issues, specifically low salaries, are major barriers to recruitment and retention within the SUD treatment profession. However, there are steps states can take to mitigate some financial concerns. First, states should at least try to insure that SUD professionals receive cost of living increases (COLAs) since salaries in the SUD treatment profession tend to lag behind most other professions, with a majority of providers making between $15,000 and $34,000 annually (Knudsen and Gabriel, 2003; Knudsen et al., 2005; Pringle and Holland, 2004; RMC Research Corporation, 2003). Without provision of COLAs, providers will find it increasingly difficult to stay in their positions, purely for financial reasons. The Pennsylvania Bureau of Drug and Alcohol Programs (BDAP) directly addresses this issue by submitting an annual COLA request to the Secretary of Health. While COLAs do not always make it to the final budget, BDAP feels it is important to continue asking for these increases to ensure COLAs remain a visible budgetary issue in the state.

- **Use Preferred Provider Contracting.** Another way to address reimbursement issues is through preferred provider contracting. This would involve collaboration between the states and the Single County Authorities to help design incentive packages for preferred providers as a way to earn more based on standardized benchmarks. In this way, providers would have the ability to secure funding above their contracted level if they could demonstrate and reach some benchmarks in terms of quality service, efficiency, etc. Pennsylvania is already exploring preferred provider contracting strategies. Beginning in the next fiscal year, BDAP will conduct an evaluation of the preferred provider contracting process currently in use by two Single County Authorities (SCAs). If deemed appropriate for statewide implementation, BDAP plans to design a "how to" training which they will offer to other SCAs.

- **Document Health Care Costs.** It is important for states to encourage all agencies and providers to document health care costs. Through these data, the state body responsible for securing drug and alcohol funding will be able to determine where the greatest needs exist. They can present such data to decision-makers and make a strong case to obtain additional funding. In New York State, OASAS and provider organizations consistently monitor cost trends so they can keep the state legislature, division of budget and governor's office informed about continuing need.

- **Offer Monetary Compensation for Staff to Attend Trainings.** While offering more effective training is important, there are still many barriers, especially financial, that prevent providers from taking advantage of it. Training is a key aspect of increasing the effectiveness of SUD treatment providers which can eventually lead to better financial opportunities based on quantification of more positive outcomes.[9] New Jersey is planning to mitigate the financial barrier to training by offering monetary compensation to providers whose employees attend training days to balance the loss of the professional's work that day.

9 States need to be aware that training alone does not change behavior (Marinelli-Casey, Domier, and Rawson, 2002). States who do offer monetary incentives for staff to attend trainings should try to encourage linkage to ongoing mentoring and training reinforcement instead of perpetuating a piecemeal training system of educational presentations. With this linkage, financial reimbursements for training can play a key role in accessing knowledge for change. The bottom line is that training without ongoing skillful supervision, feedback, coaching and mentoring does not appear to yield measurable changes in practice.

Strategies to Address Stigma:

- **Use Recognition Programs to Retain Front Line Workers and Highlight the Rewards of a Job in the SUD Profession.** Recognition of treatment professionals is important for building morale of existing workers, educating those outside the SUD profession as to the possible rewards one can receive working in the profession, and creating a supportive work atmosphere which, in turn, fosters professional improvement. All of these can play a role in recruiting new workers and retaining experienced ones. Non-monetary incentives can contribute greatly to increasing retention. One idea for recognition is to create a state-wide formal awards and recognition program that takes place once a year where employees will be recognized for special achievements and receive rewards from superiors and/or co-workers. Day-to-day recognition could include non-monetary rewards such as time off from work, birthday recognition, and acknowledgement of special accomplishments. These programs could form the basis of a statewide marketing campaign which highlights attractive, non-monetary incentives for SUD treatment professionals.

- **Get Creative with Recruitment.** Traditionally, professionals in the SUD treatment profession have come largely from the recovery community or through second career opportunities. While these are still good sources of frontline workers, workers from these sources tend to be older adults with little gender and/or cultural similarity to their patients. It is important that states increase SUD treatment professional diversity not only to maximize the effectiveness of professionals but also to ensure that different cultural and ethnic groups have models of successful people associated with the SUD treatment profession within their communities. This personal identification will greatly help to reduce stigma in these diverse communities. States can target younger and ethnically and culturally diverse workers for recruitment by focusing efforts at the high school and community college levels, taking into account the student populations within those schools, and identifying key events to use as venues at which to recruit. States can also focus recruitment attention on students in other human services degree programs, such as sociology and psychology, who may be interested in entering the SUD treatment workforce. These publicly visible recruitment venues could also be accompanied by extensive strictly educational and awareness materials to further aid in reducing stigma.

- **Create a Traveling SUD Exhibit.** States can create a traveling exhibit to be placed in schools, museums and other easily accessible public venues which use an innovative format, such as art, to personalize SUD experiences and promote public awareness to help combat stigma. This has been a successful strategy in combating stigma against depression in Texas (Bender, 2003).

Strategies to Address System Fragmentation:

- **Revamp Current Training.** One of the major challenges within the profession is the need for standardized training (Keller and Dermatis, 1999). Systematic coordination of training programs could help to repair the currently fragmented care delivery system outlined in Section I of this monograph. In addition, training without ongoing skillful supervision, feedback, coaching and mentoring does not yield measurable changes in practice. States can remedy this by:

  – Instituting standardized training for counselors and staff which might involve conducting clinical supervision trainings, including the 12 core functions, administering TAP 21 Counselor Competencies (CSAT, 1998) and developing universal course content grounded in evidence-based practices.

  – Working with providers and agencies to develop a comprehensive curriculum that agencies can offer to new employees. This may include an element of mentoring from more experienced staff.

  – Standardizing educational training needed for certification. This can be accomplished through one or both of the following: 1) creating curricula for training programs to be used statewide; and/or 2) requiring instructors to have a certain level of education and training in a subject. For example, New Jersey has already standardized course content for certification and licensure and is planning to require that all instructors have at least a master's degree and a CADC and be trained in a certain domain in order to teach the course material.

  – Implementing staff development/service improvement strategies which have demonstrated effectiveness, such as considering regulatory "reforms to reduce paper work burdens and reduce "unit of service" productivity requirements in order to encourage more regular clinical supervision (OASAS, 2004)" (Lincourt, 2005, p.1; Campbell, 2005).

  Training of trainers themselves is also important to unity within the profession. Not only is building good leadership essential to effecting change (Nanus and Dobbs, 1999), but training of trainers also ensures that leaders will have a unified vision for such change. Standardization of trainers could include collective training for all clinical supervisors within the state to teach them how to supervise counselors effectively and building consensus on the most important information to teach at training of trainers. Standardization of training for both trainers and frontline workers also helps to ensure a more uniform and improved quality of care.

- **Keep Credentials and Competencies Relevant to the Profession.** The SUD treatment profession is constantly changing. Between new technology, new treatment methods, and new therapeutic medications, there is little consensus on the best approach practitioners should take to deal with the complexities of the profession. States can assure frontline workers are trained to deal with these complexities in a uniform way by offering new certifications and licenses in specialized areas as needed. For example, OASAS in New York State is planning to implement a new stand-alone credential and a specialty designation related to compulsive gambling for the CASAC, CPP and CPS credentials. They also are working to implement a specialty designation for counselors and prevention practitioners who have completed an intensive training program in cultural diversity and competence.
- **Offer Cross-Disciplinary Education.** Increasingly, health care providers outside the SUD treatment profession encounter individuals with an SUD (O'Brien and McLellan, 1997). Unfortunately, current training for a majority of health care providers includes little or no practical information on screening, intervening or referring individuals to the proper level of SUD treatment care (McLellan and Meyers, 2004). States can remedy this by working towards curriculum infusion of SUD education into other programs, such as law, medicine, sociology, and others, as a way of cutting across some of the barriers individuals seeking treatment encounter. The goal is to someday provide training for doctors, nurses, those in the criminal justice realm, and others to learn more about SUDs. This will serve to increase the population of knowledgeable, and, eventually, certified or licensed professionals, who treat SUDs.
- **Improve Clinical Supervision.** As mentioned in Section III above, clinical supervision is widely recognized as an evidence-based practice which offers effective training and skill development (Dixon, n.d.a). Clinical supervision is not only important for standardizing practice among providers, but also research has proven that in agencies which integrate clinical supervision into practice, staff are appreciative, management makes meaningful changes in administration of human resources, quality of care improves, and evidence-based practices are adopted with more fidelity and greater likelihood of producing improved outcomes (Dixon, n.d.b; Keller and Dermatis, 1999; National Center for Education and Training on Addiction, 2005; SAMHSA, 2003b). States can encourage agencies to institute clinical supervision practices by offering training for administrators related to calculating indirect costs and directing agencies to add clinical supervision (and other indirect costs) into rate structures. Clinical supervision also can serve as a natural career ladder if funded as such.

Strategies to Address Technology Barriers:

- **Encourage and/or Facilitate Collaborations with Local Researchers.** Most states typically house a wealth of research facilities including universities, colleges and independent research groups that tend to have the latest technology at their disposal. At the same time, agencies and programs offer a unique opportunity for clinical trials. By linking researchers with agencies and programs, states could not only help providers better track the effectiveness of services, but also the research partnerships would provide a wealth of information to states that need data to assess and monitor the condition of the SUD treatment workforce (Carise, Cornely, Gurel, 2002).
- **Offer State-Sponsored Technology Training Courses.** While a number of programs and agencies may not have routine access to technology, others who do have computers and internet access may not know how to find and/or strategically utilize these resources to best benefit SUD treatment. States can remedy this by offering technology training courses at all statewide training venues, such as the Regional Training Institutes offered in Pennsylvania, which could range from basic to complex. States can assess technology needs of their providers through surveys of agencies and provider organizations and tailor courses to these needs.

Conclusion

The SUD treatment workforce crisis has been an area of growing concern for many years. While researchers continue to provide data suggesting that the profession is in a declining phase, many providers, policymakers and others have been working diligently with great success to build their workforces. New York has been and continues to be an outstanding example of a state committed to and successfully achieving its goal of stimulating recruitment and retention of addictions professionals. Drawing on New York's innovative work, the NeATTC has brought information on workforce development strategies to New Jersey and Pennsylvania while helping these states use New York's experience to launch programs of their own.

The NeATTC would like this document to serve as an example of how states and regions can work together to reverse troubling SUD treatment workforce trends, as a guide for other states and regions who have not yet begun or are in the formative stages of their own workforce development activities, and as an example of what professionals from all sectors, both within and outside the SUD profession, can achieve if they work together. However, it is important all invested in SUD treatment workforce development do not lose sight of the fact that the intent of recruitment, retention, training and other efforts is to ensure that providers can offer more and better treatment to individuals who need it. With more and better treatment and data to document the change, the profession can go a long way toward breaking down the barriers to improved treatment that exist today. This monograph highlights the first and necessary step the profession needs to take to achieve this vision.

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